

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very Important. See instructions on back of certificate.

1 PLACE OF DEATH

4868

STATE OF MARYLAND  
CERTIFICATE OF DEATHCounty DorchesterRegistration Dist. No. 116Village or City Cambridge (No. 68, Park Lane St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Salomon Allen

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE colored 5 SINGLE, MARRIED, WIDDED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH Unknown, 1853  
(Month) (Day) (Year)

7 AGE 61 yrs. Unknown mos. Unknown ds. OR min. ?  
If LESS than 1 day.....hrs.

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Gen. Laborer  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country) Ind

10 NAME OF FATHER John Allen

11 BIRTHPLACE OF FATHER  
(State or country) Ind

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER  
(State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter Allen(Address) High St. Cambridge, Md

15 Filed May 23, 1914 E. E. Wolff

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 23, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY that I attended deceased from May 20<sup>th</sup>, 1914, to May 24<sup>th</sup>, 1914.

that I last saw him alive on May 23<sup>rd</sup>, 1914.

and that death occurred on the date stated above, at 9:30 p. m.

The CAUSE OF DEATH\* was as follows:

Bright's Disease  
One year duration

Acute Indigestion  
(Duration) Unknown yrs. Unknown mos. Unknown ds.

Contributory Temp 104° - Inguinal pain  
Secondary Constipation 5-13

(Signed) Thomas Lynch Cole, M. D.  
May 23, 1914 (Address) Cambridge, Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Cambridge, Md DATE OF BURIAL May 24, 1914

20 UNDERTAKER Turner & Clair ADDRESS City

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

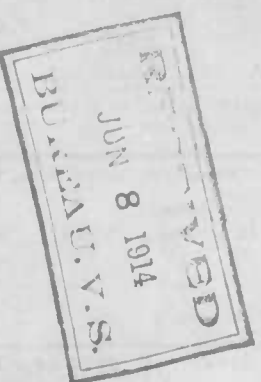
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



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| 1 PLACE OF DEATH  |   | STATE OF MARYLAND   |  |
|---|---|---|--|
| County <u>Lorchester</u>  |   | CERTIFICATE OF DEATH  |  |
| Village or City <u>Cambridge</u> (No. <u>222</u> , <u>Washington</u> St.; <u>Washington</u> Ward)   |   | Registration Dist. No. <u>116</u>   |  |
| 2 FULL NAME <u>Thomas E. Burley</u>   |   | [If death occurred in a hospital or institution, give its NAME instead of street and number.] |  |
| PERSONAL AND STATISTICAL PARTICULARS  |   |   |  |
| 3 SEX<br><u>male</u>  | 4 COLOR OR RACE<br><u>colored</u>                         | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br><u>married</u><br>(Write the word)                 |  |
| 6 DATE OF BIRTH<br><u>Unknown</u> , 18 <u>38</u><br>(Month) (Day) (Year)  |   |   |  |
| 7 AGE<br><u>76</u> yrs. <u>Unknown</u> mos. <u>Unknown</u> ds.  |   | If LESS than 1 day, <u>Unknown</u> hrs. OR <u>Unknown</u> min. ?                              |  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work <u>Gardener</u><br>(b) General nature of industry, business, or establishment in which employed (or employer)   |   |   |  |
| 9 BIRTHPLACE (State or country) <u>Ind.</u>   |   |   |  |
| PARENTS   | 10 NAME OF FATHER <u>Unknown</u>                          |   |  |
|   | 11 BIRTHPLACE OF FATHER (State or country) <u>Unknown</u> |   |  |
|   | 12 MAIDEN NAME OF MOTHER <u>Unknown</u>                   |   |  |
|   | 13 BIRTHPLACE OF MOTHER (State or country) <u>Unknown</u> |   |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>Jerome Burley</u><br>(Address) <u>222 Washington St. City</u>  |   |   |  |
| 15 Filed <u>May 2</u> , 191 <u>4</u>  |   | E. E. Webb<br>REGISTRAR   |  |
| MEDICAL CERTIFICATE OF DEATH  |   |   |  |
| 18 DATE OF DEATH <u>May 1</u> , 191 <u>4</u><br>(Month) (Day) (Year)  |   |   |  |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>Apr</u> <u>1</u> , 191 <u>4</u> to <u>May 1</u> , 191 <u>4</u> , that I last saw him alive on <u>May 1</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>7:30 P.</u> m.  |   |   |  |
| The CAUSE OF DEATH* was as follows:<br><u>When seen patient was in coma. &amp; info from sister that he chronic nephritis</u>   |   |   |  |
| (Duration) <u>Unknown</u> yrs. <u>Unknown</u> mos. <u>Unknown</u> ds.   |   |   |  |
| Contributory<br>Secondary   |   |   |  |
| (Signed) <u>Thos. E. Burley</u> , M. D.<br><u>Ind.</u> , 191 <u>4</u> . (Address) <u>Cambridge Ind.</u>   |   |   |  |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.   |   |   |  |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death <u>Unknown</u> yrs. <u>Unknown</u> mos. <u>Unknown</u> ds. In the State <u>Unknown</u> yrs. <u>Unknown</u> mos. <u>Unknown</u> ds.<br>Where was disease contracted, if not at place of death?<br>Former or usual residence |   |   |  |
| 19 PLACE OF BURIAL OR REMOVAL<br><u>Cambridge, Ind.</u>   |   | DATE OF BURIAL<br><u>Mar 3</u> , 191 <u>4</u>   |  |
| 20 UNDERTAKER<br><u>Turner &amp; Dr. Clair</u>  |   | ADDRESS<br><u>City</u>  |  |

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

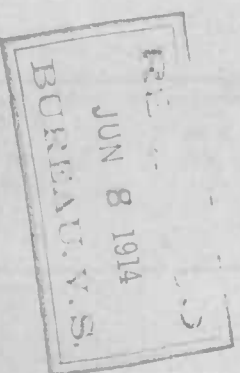
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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|   |   |   |  |  |  |   |  |
|---|---|---|--|--|--|---|--|
| 1 PLACE OF DEATH<br>County <u>Dorchester Co</u>   |   | 4870  |  | 28   |  | STATE OF MARYLAND<br>CERTIFICATE OF DEATH |  |
| Village or City <u>Cambridge</u> (No. _____)  |   | St. _____   |  | Ward _____                                     |  | Registration Dist. No. <u>116</u>         |  |
| 2 FULL NAME <u>Walter D. Campen</u>   |   |   |  |  |  |   |  |
| PERSONAL AND STATISTICAL PARTICULARS  |   |   |  |  |  |   |  |
| 3 SEX<br><u>male</u>  | 4 COLOR OR RACE<br><u>color</u>                                     | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br>(Write the word) <u>Single</u> |  |  |  |   |  |
| 6 DATE OF BIRTH<br><u>Don't know</u> , 1872   |   | (Month) _____ (Day) _____ (Year) _____                                    |  |  |  |   |  |
| 7 AGE<br><u>42</u> yrs. _____ mos. _____ ds.  |   | If LESS than 1 day, _____ hrs. _____ min. ?                               |  |  |  |   |  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work <u>Labor</u><br>(b) General nature of industry, business, or establishment in which employed (or employer) _____  |   |   |  |  |  |   |  |
| 9 BIRTHPLACE (State or country) <u>Cambridge Md</u>   |   |   |  |  |  |   |  |
| PARENTS   | 10 NAME OF FATHER <u>Henry Campen</u>                               |   |  |  |  |   |  |
|   | 11 BIRTHPLACE OF FATHER (State or country) <u>Dorchester Co. Md</u> |   |  |  |  |   |  |
|   | 12 MAIDEN NAME OF MOTHER <u>Margaret Thompson</u>                   |   |  |  |  |   |  |
|   | 13 BIRTHPLACE OF MOTHER (State or country) <u>Dorchester Co. Md</u> |   |  |  |  |   |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>May Campen</u><br>(Address) <u>Cambridge</u>   |   |   |  |  |  |   |  |
| 16 Filed <u>May 11, 1914</u> <u>E. E. Webb</u><br>REGISTRAR   |   |   |  |  |  |   |  |
| MEDICAL CERTIFICATE OF DEATH  |   |   |  |  |  |   |  |
| 16 DATE OF DEATH <u>May 10</u> , 191 <u>4</u><br>(Month) _____ (Day) _____ (Year) _____   |   |   |  |  |  |   |  |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>about July 1</u> , 191 <u>4</u> , to <u>May 10</u> , 191 <u>4</u> , that I last saw h. <u>live</u> alive on <u>about April 15</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>12.30 A</u> m.             |   |   |  |  |  |   |  |
| The CAUSE OF DEATH* was as follows:<br><u>Pulmonary Tuberculosis</u>  |   |   |  |  |  |   |  |
| (Duration) _____ yrs. <u>6</u> mos. _____ ds.   |   |   |  |  |  |   |  |
| Contributory _____<br>Secondary _____   |   |   |  |  |  |   |  |
| (Signed) <u>Dr. G. L. Brown</u> , M. D.<br><u>May 11</u> , 191 <u>4</u> (Address) <u>Cambridge Md</u>   |   |   |  |  |  |   |  |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.   |   |   |  |  |  |   |  |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death _____ yrs. _____ mos. _____ ds. in the State _____ yrs. _____ mos. _____ ds.<br>Where was disease contracted, If not at place of death? _____<br>Former or usual residence _____ |   |   |  |  |  |   |  |
| 19 PLACE OF BURIAL OR REMOVAL<br><u>Waltham Cemetery</u>  |   |   |  | DATE OF BURIAL<br><u>May 12</u> , 191 <u>4</u> |  |   |  |
| 20 UNDERTAKER<br><u>LeCompt Hays</u>  |   |   |  | ADDRESS<br><u>Cambridge</u>                    |  |   |  |



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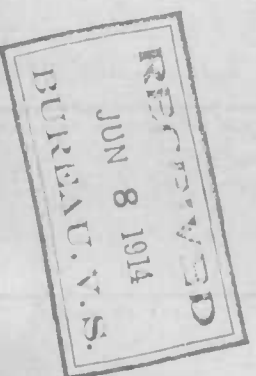
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1 PLACE OF DEATH 4871  
County Dorchester Co

Village or City Cambridge (No. \_\_\_\_\_, St. \_\_\_\_\_ Ward \_\_\_\_\_)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 116

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John Cann

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Not Known  
(Write the word)

6 DATE OF BIRTH Dont Know, 1 (Month) (Day) (Year)

7 AGE 24 yrs. — mos. — ds. OR LESS than 1 day, — hrs. — min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Sailor  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Dont Know

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (State or country) Dont Know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Dr Goldsborough

(Address) Cambridge Ma

15 Filed May 16, 1914 E.E. Wolf  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 16, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1914 to May 16, 1914, that I last saw him alive on May 15, 1914

and that death occurred on the date stated above, at 12.05 P m.

The CAUSE OF DEATH\* was as follows:

Typhoid Fever

(Duration) — yrs. — mos. — ds. 8  
Contributory meningitis  
Secondary

(Signed) D. M. Goldsborough, M. D.  
May 16, 1914 (Address) Cambridge Ma

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. 5 In the State — yrs. — mos. — ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Cambridge Cemetery DATE OF BURIAL May 17, 1914

20 UNDERTAKER W. L. Wolf ADDRESS Cambridge

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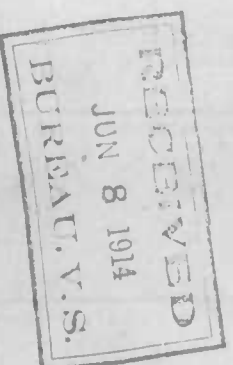
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 4872  
County Dorchester

Village or City Cambridge (No. \_\_\_\_\_) St.; \_\_\_\_\_ Ward)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 116

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Joseph Roemish

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Don't know, 1853  
(Month) (Day) (Year)

7 AGE 61 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. It LESS than 1 day \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work former  
(b) General nature of industry, business, or establishment in which employed (or employer) none

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER Joseph Roemish

11 BIRTHPLACE OF FATHER (State or country) md

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (State or country) Don't know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Maria Roemish

(Address) Cambridge md

15 Filled May 28, 1914 Robt H Matthews  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 27, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1914 to May 28, 1914  
that I last saw him alive on May 29, 1914

and that death occurred on the date stated above, at \_\_\_\_\_ m.  
The CAUSE OF DEATH\* was as follows:

Bronchial Asthma

(Duration) \_\_\_\_\_ yrs. 2 mos. 27 ds.  
Contributory General ordering with Asthma  
Secondary

(Duration) \_\_\_\_\_ yrs. 10 ds.  
(Signed) Thos Lynch Bell, M. D.  
May 28, 1914 (Address) Cambridge md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Cambridge md DATE OF BURIAL May 28, 1914

20 UNDERTAKER Levin H Bayne ADDRESS Cambridge md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., requesting V. S. No. 1. md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

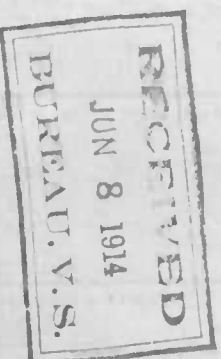
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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SELF-inflicted, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 4873  
County Dorchester

Village or City Cambridge (No. nd) St.; Ward)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 116

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Isaiah DeCan

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH don't know (Month) (Day) (Year)

7 AGE unknown If LESS than 1 day, hrs. yrs. mos. ds. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work house keeper (b) General nature of industry, business, or establishment in which employed (or employer) none

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER don't know

11 BIRTHPLACE OF FATHER (State or country) don't know

12 MAIDEN NAME OF MOTHER don't know

13 BIRTHPLACE OF MOTHER (State or country) don't know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Isaiah DeCan

(Address) Cambridge md

15 Filed May 24, 1914 E. E. Wolff

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 24, 1914  
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from March 1st 1914 to May 24th 1914

that I last saw him alive on May 23rd 1914

and that death occurred on the date stated above, at 12:30 P. M.

The CAUSE OF DEATH\* was as follows:

Exhaustion  
following night's sleep  
(Duration) yrs. 2 mos. 24 ds.

Contributory Bright's Disease  
Secondary (Duration) yrs. 2 mos. 24 ds.

(Signed) The Arch Bell, M. D.  
May 24, 1914 (Address) Cambridge md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Cambridge md DATE OF BURIAL May 24, 1914

20 UNDERTAKER Lewis H. Bagnen ADDRESS Cambridge md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

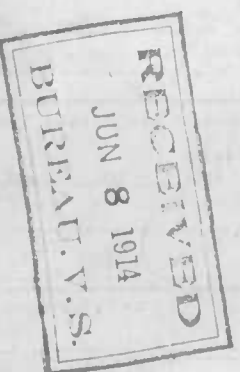
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|   |                                   |   |  |
|---|-----------------------------------|---|--|
| 1 PLACE OF DEATH <u>4874</u>  |                                   | STATE OF MARYLAND<br>CERTIFICATE OF DEATH   |  |
| County <u>Dorchester</u>  |                                   | Registration Dist. No. <u>116</u>   |  |
| Village or City <u>Cambridge Md</u> (No. _____) St. _____ Ward _____  |                                   | [If death occurred in a hospital or institution, give its NAME instead of street and number.]   |  |
| 2 FULL NAME <u>Mary J. Thompson</u>   |                                   |   |  |
| PERSONAL AND STATISTICAL PARTICULARS  |                                   |   |  |
| 3 SEX<br><u>Female</u>  | 4 COLOR OR RACE<br><u>Colored</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>   |  |
| 6 DATE OF BIRTH<br><u>Unknown, 1864</u>   |                                   |   |  |
| 7 AGE<br><u>53</u> yrs. _____ mos. _____ ds. OR _____ min. ?  |                                   | 16 DATE OF DEATH<br><u>May 18</u> , 19 <u>14</u><br>(Month) (Day) (Year)  |  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work <u>housekeeper</u><br>(b) General nature of industry, business, or establishment in which employed (or employer) <u>no</u>  |                                   | 17 I HEREBY CERTIFY, That I attended deceased from <u>Jan 1<sup>st</sup></u> , 19 <u>14</u> , to <u>Feb 10<sup>th</sup></u> , 19 <u>14</u> , that I last saw him alive on <u>Feb 10<sup>th</sup></u> , 19 <u>14</u> , and that death occurred on the date stated above, at <u>2:30</u> p.m. |  |
| 9 BIRTHPLACE (State or country) <u>Beckmeck Md</u>  |                                   | The CAUSE OF DEATH* was as follows:<br><u>General Senility</u><br><u>Pulmonary tuberculosis</u>   |  |
| 10 NAME OF FATHER<br><u>Henry Banks</u>   |                                   | Contributory (Duration) _____ yrs. <u>4</u> mos. <u>19</u> ds.  |  |
| 11 BIRTHPLACE OF FATHER (State or country) <u>Md</u>  |                                   | Secondary (Duration) _____ yrs. <u>4</u> mos. <u>19</u> ds.   |  |
| 12 MAIDEN NAME OF MOTHER<br><u>Sarah C. Long</u>  |                                   | (Signed) <u>Geo Lynch Coll.</u> , M. D.<br><u>May 19<sup>th</sup> 1914</u> (Address) <u>Cambridge Md</u>  |  |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Md</u>  |                                   | *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.   |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Henry Thompson</u><br>(Address) <u>Cambridge Md</u>   |                                   |   |  |
| 15 Filled <u>May 19</u> , 19 <u>14</u> <u>E. E. Woff.</u><br>REGISTRAR  |                                   |   |  |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.<br>Where was disease contracted, If not at place of death?<br>Former or usual residence _____ |                                   | 19 PLACE OF BURIAL OR REMOVAL<br><u>Cambridge Md</u>  |  |
| 20 UNDERTAKER<br><u>Leung H. Bame</u>   |                                   | DATE OF BURIAL<br><u>May 20</u> , 19 <u>14</u>  |  |
|   |                                   | ADDRESS<br><u>Cambridge Md</u>  |  |

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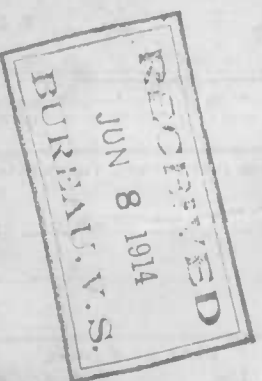
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1 PLACE OF DEATH 4875  
County Dorchester

Village or City Crofton (No. \_\_\_\_\_, St. \_\_\_\_\_ Ward \_\_\_\_\_)

2 FULL NAME John W. Emuals

Registration Dist. No. 114

[It death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Caucasian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH Jan 23, 1890  
(Month) (Day) (Year)

7 AGE 24 yrs. 4 mos. ds. If LESS than 1 day, \_\_\_\_\_ hrs. OR mld. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Cyberman  
(b) General nature of industry, business, or establishment in which employed (or employer) V

9 BIRTHPLACE (State or country) Dorchester Co

10 NAME OF FATHER John H. Emuals

11 BIRTHPLACE OF FATHER (State or country) Dorchester Co

12 MAIDEN NAME OF MOTHER Mary Strofer

13 BIRTHPLACE OF MOTHER (State or country) Dorchester

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miles Brugato

(Address) Crofton, Md.

15 Filed May 24, 1914 W J Busick  
REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 23, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1914 to May 22, 1914, that I last saw him alive on May 24, 1914

and that death occurred on the date stated above, at 9 P m.

The CAUSE OF DEATH\* was as follows:

Acute Gastritis

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Contributory (Secondary) Typhoid Fever

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) Victor C. Carroll, M. D.  
May 23, 1914 (Address) Crofton, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Beach ground May 25, 1914

20 UNDERTAKER ADDRESS

A J Kirwan Crofton

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

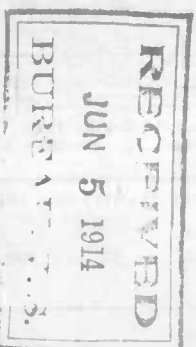
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on Statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 4876

County DorchesterVillage or City Cambridge (No. 6, Thir)Registration Dist. No. 116

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Robert Groswell Evans

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH 30 Sept. 28, 1914  
(Month) (Day) (Year)

7 AGE 34 yrs. 7 mos. 18 ds. OR 1 day, 1 hrs. 1 min. ?  
It LESS than 1 day, hrs. min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Sailor  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER John R. Evans

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret E. Merrick

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas R. Evans(Address) Cambridge Md

15 Filed May 16, 1914 E. E. Wolff  
REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 16, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from me, 1914, to May 18, 1914,  
that I last saw him alive on May 14, 1914.

and that death occurred on the date stated above, at 5 a m.

The CAUSE OF DEATH\* was as follows:

Tuberculosis(Duration) 2 yrs. 0 mos. 0 ds.Contributory  
Secondary(Duration) 0 yrs. 0 mos. 0 ds.

(Signed) John W. Mace, M. D.  
May 16, 1914 (Address) Cambridge

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted,  
If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Cambridge Md DATE OF BURIAL May 17, 1914

20 UNDERTAKER H. H. Hillis & Son ADDRESS Cambridge Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

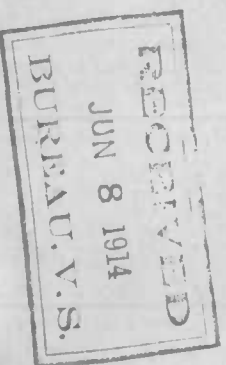
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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|  |  |  |    |   |   |  |
|--|--|--|----|---|---|--|
| 1 PLACE OF DEATH<br>County <u>Dorchester</u>   |  | 4877   | 78 |   | STATE OF MARYLAND<br>CERTIFICATE OF DEATH |  |
| Village or City <u>Bishop's Head, Md.</u> (No. <u>10</u> , St. <u>      </u> Ward <u>      </u> )  |  | Registration Dist. No. <u>119</u>  |    | [If death occurred in a hospital or institution, give its NAME instead of street and number.] |   |  |
| 2 FULL NAME <u>James M. Foster</u>   |  |  |    |   |   |  |
| PERSONAL AND STATISTICAL PARTICULARS   |  |  |    |   |   |  |
| 3 SEX<br><u>male</u>   | 4 COLOR OR RACE<br><u>negro</u>                              | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)<br><u>Single</u>  |    |   |   |  |
| 6 DATE OF BIRTH<br><u>May 10, 1887</u><br>(Month) (Day) (Year)   |  | 7 AGE<br><u>27</u> yrs. <u>0</u> mos. <u>17</u> ds. If LESS than 1 day, <u>      </u> hrs. OR <u>      </u> min. ? |    |   |   |  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work <u>Farmer</u><br>(b) General nature of industry, business, or establishment in which employed (or employer) <u>Working as a hand</u>   |  |  |    |   |   |  |
| 9 BIRTHPLACE (State or country) <u>Dorchester Co. Md.</u>  |  |  |    |   |   |  |
| PARENTS  | 10 NAME OF FATHER <u>Demmond Foster</u>                      |  |    |   |   |  |
|  | 11 BIRTHPLACE OF FATHER (State or country) <u>Crafo. Md.</u> |  |    |   |   |  |
|  | 12 MAIDEN NAME OF MOTHER <u>Emily Foster</u>                 |  |    |   |   |  |
|  | 13 BIRTHPLACE OF MOTHER (State or country) <u>Crafo Md.</u>  |  |    |   |   |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>Joe A. Foster</u><br>(Address) <u>Bishop's Head, Md.</u>  |  |  |    |   |   |  |
| 15 Filed <u>May 27, 1914</u> <u>W. H. RITCHIE</u><br>REGISTRAR   |  |  |    |   |   |  |
| MEDICAL CERTIFICATE OF DEATH   |  |  |    |   |   |  |
| 16 DATE OF DEATH <u>May 26, 1914</u><br>(Month) (Day) (Year)   |  |  |    |   |   |  |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>April 4, 1914</u> to <u>May 21, 1914</u><br>that I last saw him alive on <u>May 21, 1914</u><br>and that death occurred on the date stated above, at <u>11:30 P. m.</u><br>The CAUSE OF DEATH* was as follows:<br><u>Tuberculosis of the Lungs</u><br>(Duration) <u>      </u> yrs. <u>10</u> mos. <u>0</u> ds.<br>Contributory <u>Hemoptysis</u><br>Secondary <u>      </u> (Duration) <u>      </u> yrs. <u>      </u> mos. <u>15</u> minutes<br>(Signed) <u>P. H. Taves</u> , M. D.<br><u>May 27, 1914</u> (Address) <u>Bishop's Head Md.</u> |  |  |    |   |   |  |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.  |  |  |    |   |   |  |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death <u>      </u> yrs. <u>      </u> mos. <u>      </u> ds. In the State <u>      </u> yrs. <u>      </u> mos. <u>      </u> ds.<br>Where was disease contracted, If not at place of death?<br>Former or usual residence <u>      </u>  |  |  |    |   |   |  |
| 19 PLACE OF BURIAL OR REMOVAL <u>Crafo Md.</u>   |  |  |    | DATE OF BURIAL <u>May 27, 1914</u>  |   |  |
| 20 UNDERTAKER <u>A. J. KIRWAN</u>  |  |  |    | ADDRESS <u>Crafo Md.</u>  |   |  |

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# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

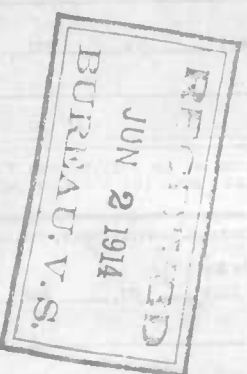
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*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Irritation," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as *accidental*, *suicidal*, or *homicidal*, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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|  |   |   |  |   |  |
|--|---|---|--|---|--|
| 1 PLACE OF DEATH<br>County <u>Dorchester</u>   |   | 4878  |  | STATE OF MARYLAND<br>CERTIFICATE OF DEATH   |  |
| Village or City <u>Cambridge</u> (No. <u>Hospital</u> )  |   | Registration Dist. No. <u>116</u>                                     |  | [If death occurred in a hospital or institution, give its NAME instead of street and number.] |  |
| 2 FULL NAME <u>John Jefferson</u>  |   |   |  |   |  |
| PERSONAL AND STATISTICAL PARTICULARS   |   |   |  |   |  |
| 3 SEX<br><u>Male</u>   | 4 COLOR OR RACE<br><u>White</u>                           | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br>(Write the word) <u>2e</u> |  |   |  |
| 6 DATE OF BIRTH<br><u>Unknown</u> (Month) (Day) (Year)   |   |   |  |   |  |
| 7 AGE<br><u>about 65</u> yrs. .... mos. .... ds. If LESS than 1 day, .... hrs. OR .... min. ?  |   |   |  |   |  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work <u>Unknown</u><br>(b) General nature of industry, business, or establishment in which employed (or employer)   |   |   |  |   |  |
| 9 BIRTHPLACE (State or country) <u>Unknown</u>   |   |   |  |   |  |
| PARENTS  | 10 NAME OF FATHER <u>Unknown</u>                          |   |  |   |  |
|  | 11 BIRTHPLACE OF FATHER (State or country) <u>Unknown</u> |   |  |   |  |
|  | 12 MAIDEN NAME OF MOTHER <u>Unknown</u>                   |   |  |   |  |
|  | 13 BIRTHPLACE OF MOTHER (State or country) <u>Unknown</u> |   |  |   |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>Cambridge Ind. Hospital</u><br>(Address) _____  |   |   |  |   |  |
| 15 Filed <u>May 23</u> , 191 <u>4</u> <u>E E Wolff</u><br>REGISTRAR  |   |   |  |   |  |
| MEDICAL CERTIFICATE OF DEATH   |   |   |  |   |  |
| 16 DATE OF DEATH <u>May</u> <u>23</u> , 191 <u>4</u><br>(Month) (Day) (Year)   |   |   |  |   |  |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>May 21</u> , 191 <u>4</u> , to <u>May 23</u> , 191 <u>4</u> , that I last saw him alive on <u>May 22</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>2. A.</u> m.<br>The CAUSE OF DEATH* was as follows:<br><u>Tubercular Tuberculosis</u><br>(Duration) .... yrs. .... mos. .... ds.<br>Contributory Secondary<br>(Duration) .... yrs. .... mos. .... ds.<br>(Signed) <u>Dr. Goldsborough</u> , M. D.<br><u>May 23</u> , 191 <u>4</u> . (Address) <u>Cambridge Ind.</u><br>*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. |   |   |  |   |  |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.<br>Where was disease contracted, If not at place of death?<br>Former or usual residence _____  |   |   |  |   |  |
| 19 PLACE OF BURIAL OR REMOVAL<br><u>Federalburg, Ind.</u>  |   |   |  | DATE OF BURIAL<br><u>May 24</u> , 191 <u>4</u>  |  |
| 20 UNDERTAKER<br><u>W. H. With &amp; Sons</u>  |   |   |  | ADDRESS<br><u>Cambridge Ind.</u>  |  |

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

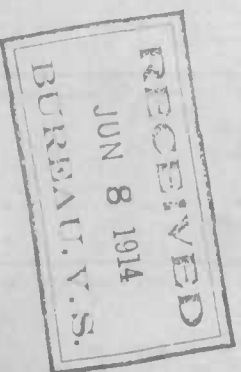
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cause" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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<sup>1</sup> PLACE OF DEATH 4879  
County Dorchester

90 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 114

Village or City Crapo (No. \_\_\_\_\_, \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

<sup>2</sup> FULL NAME Ada Johnson

## PERSONAL AND STATISTICAL PARTICULARS

<sup>3</sup> SEX Female <sup>4</sup> COLOR OR RACE negro <sup>5</sup> SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

<sup>6</sup> DATE OF BIRTH Sept 29, 1914  
(Month) (Day) (Year)

<sup>7</sup> AGE 7 yrs. 21 mos. 21 ds. If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

<sup>8</sup> OCCUPATION  
(a) Trade, profession, or particular kind of work none  
(b) General nature of industry, business, or establishment in which employed (or employer) none

<sup>9</sup> BIRTHPLACE (State or country) Dorchester Co, Md.

<sup>10</sup> NAME OF FATHER Ernest Johnson

<sup>11</sup> BIRTHPLACE OF FATHER (State or country) Crapo, Md

<sup>12</sup> MAIDEN NAME OF MOTHER Lena Foster

<sup>13</sup> BIRTHPLACE OF MOTHER (State or country) Bishop's Head, Md

<sup>14</sup> THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ernest Johnson

(Address) Crapo Md

<sup>15</sup> Filed May 21, 1914 W J Busick  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

<sup>16</sup> DATE OF DEATH May 20, 1914  
(Month) (Day) (Year)

<sup>17</sup> I HEREBY CERTIFY, That I attended deceased from May 13, 1914, to May 17, 1914.

that I last saw him alive on May 17, 1914.

and that death occurred on the date stated above, at 9 P. m.

The CAUSE OF DEATH\* was as follows:

Chronic Bronchitis

(Duration) \_\_\_\_\_ yrs. 6 mos. \_\_\_\_\_ ds.

Contributory Broncho pneumonia  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 28 ds.

(Signed) P. H. Jones, M. D.

May 21, 1914 (Address) Wingate, Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

<sup>18</sup> LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. to the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

<sup>19</sup> PLACE OF BURIAL OR REMOVAL Crapo DATE OF BURIAL May 21, 1914

<sup>20</sup> UNDERTAKER W G L Robinson ADDRESS Wingate Md



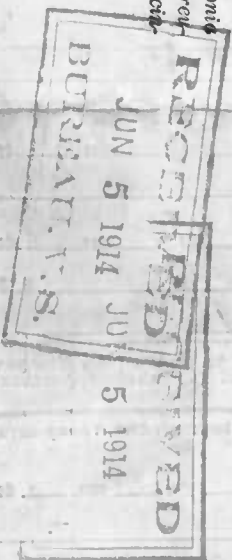
# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

4880

County

Anchorage

Village or City

Ainey

(No.)

St.; Ward)

Registration Dist. No. 116

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Florina V. Jones

## PERSONAL AND STATISTICAL PARTICULARS

|   |                            |   |
|---|----------------------------|---|
| 3 SEX<br>Female   | 4 COLOR OR RACE<br>Colored | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br>(Write the word)<br>Single |
| 6 DATE OF BIRTH<br>April 28, 1913<br>(Month) (Day) (Year) |                            |   |
| 7 AGE<br>1 yrs. 1 mos. 4 ds.                              |                            | It LESS than 1 day, hrs. OR min. ?                                    |

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

## 9 BIRTHPLACE

(State or country)

Anchorage, Ind.

## PARENTS

## 10 NAME OF FATHER

Thos. H. Jones

## 11 BIRTHPLACE OF FATHER

(State or country)

Or. Co. Ind.

## 12 MAIDEN NAME OF MOTHER

Florina A. V. Jones

## 13 BIRTHPLACE OF MOTHER

(State or country)

Or. Co. Ind.

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Thos. Jones

(Address)

Ainey, Ind.

## 15

Filed

May 29, 1914

E. E. Walcott

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

8

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 28, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1914 to May 22, 1914

that I last saw him alive on May 22, 1914

and that death occurred on the date stated above, at 10 a. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

Contributory Pulmonary Tuberculosis  
Secondary(Signed) E. E. Walcott, M. D.  
5/29, 1914 (Address) Anchorage, Ind.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Ainey, Ind.

## DATE OF BURIAL

May 29, 1914

## 20 UNDERTAKER

John Henry Wilson

## ADDRESS

Ainey, Ind.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

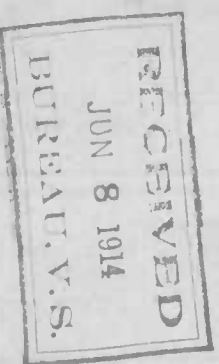
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|  |   |   |  |
|--|---|---|--|
| 1 PLACE OF DEATH <u>4881</u>   |   | STATE OF MARYLAND   |  |
| County <u>Washington</u>   |   | CERTIFICATE OF DEATH  |  |
| Village or City <u>Cambridge</u> (No. <u>21</u> , <u>Cross</u> )   |   | Registration Dist. No. <u>116</u>   |  |
| 2 FULL NAME <u>John A. Keene</u>   |   | [If death occurred in a hospital or institution, give its NAME instead of street and number.] |  |
| PERSONAL AND STATISTICAL PARTICULARS   |   |   |  |
| 3 SEX<br><u>Male</u>   | 4 COLOR OR RACE<br><u>colored</u>                           | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br><u>married</u><br>(Write the word)                 |  |
| 6 DATE OF BIRTH<br><u>Unknown</u> , 18 <u>69</u><br>(Month) (Day) (Year)   |   |   |  |
| 7 AGE<br><u>45</u> yrs. <u>Unknown</u> mos. <u>Unknown</u> ds.   |   | If LESS than<br>1 day, <u>Unknown</u> hrs.<br>OR <u>Unknown</u> min. ?                        |  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work<br>(b) General nature of industry, business, or establishment in which employed (or employer)<br><u>John A. Keene</u>  |   |   |  |
| 9 BIRTHPLACE<br>(State or country)<br><u>Md.</u>   |   |   |  |
| PARENTS  | 10 NAME OF FATHER<br><u>John Keene</u>                      |   |  |
|  | 11 BIRTHPLACE OF FATHER<br>(State or country)<br><u>Md.</u> |   |  |
|  | 12 MAIDEN NAME OF MOTHER<br><u>Maria Ross</u>               |   |  |
|  | 13 BIRTHPLACE OF MOTHER<br>(State or country)<br><u>Md.</u> |   |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>Margaret A. Keene</u><br>(Address) <u>21 Cross St. Cambridge Md.</u>  |   |   |  |
| 15<br>Filed <u>May 15</u> , 191 <u>4</u> <u>E. E. Wolfe</u><br>REGISTRAR   |   |   |  |
| MEDICAL CERTIFICATE OF DEATH   |   |   |  |
| 16 DATE OF DEATH<br><u>May 25</u> , 191 <u>4</u><br>(Month) (Day) (Year)   |   |   |  |
| 17 I HEREBY CERTIFY, That I attended deceased from<br><u>May 22</u> , 191 <u>4</u> , to <u>May 25</u> , 191 <u>4</u> .<br>that I last saw him alive on <u>May 24</u> , 191 <u>4</u> .<br>and that death occurred on the date stated above, at <u>4 A.</u> m.<br>The CAUSE OF DEATH* was as follows:<br><u>Lobar Pneumonia - (Primary -</u><br><u>2019</u><br>(Duration) <u>Chas</u> yrs. <u>10</u> mos. <u>0</u> ds. |   |   |  |
| Contributory<br>Secondary<br>(Duration) <u>Chas</u> yrs. <u>10</u> mos. <u>0</u> ds.   |   |   |  |
| (Signed) <u>E. E. Wolfe</u> , M. D.<br><u>May 20</u> , 191 <u>4</u> (Address) <u>Cambridge Md.</u>   |   |   |  |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.  |   |   |  |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death <u>Unknown</u> yrs. <u>Unknown</u> mos. <u>Unknown</u> ds. In the State <u>Unknown</u> yrs. <u>Unknown</u> mos. <u>Unknown</u> ds.<br>Where was disease contracted,<br>If not at place of death?<br>Former or usual residence   |   |   |  |
| 19 PLACE OF BURIAL OR REMOVAL<br><u>Cambridge Md.</u>  |   | DATE OF BURIAL<br><u>May 26</u> , 191 <u>4</u>  |  |
| 20 UNDERTAKER<br><u>James L. St. Clair</u>   |   | ADDRESS<br><u>City</u>  |  |

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

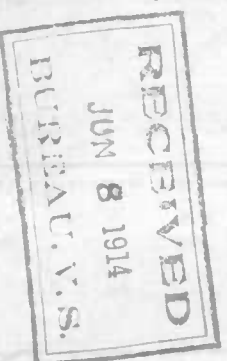
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1 PLACE OF DEATH 4882  
County Worcester

Village or City near Williamsburg St.; \_\_\_\_\_ Ward) [It death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary Elizabeth Kennedy

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Feb. 21, 1884  
(Month) (Day) (Year)

7 AGE 30 yrs. 2 mos. 15 ds. It LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work. House work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

PARENTS

10 NAME OF FATHER J. M. Paul

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah J. Lord

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Daniel J. Kennedy  
(Address) Williamsburg, Ind.

15 Filed May 6, 1914 Robert L. Hastings  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 6, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1914, to May 6, 1914, that I last saw her alive on May 6, 1914, and that death occurred on the date stated above, at 2 A m.

The CAUSE OF DEATH\* was as follows:  
Placenta Praevia  
Centralis

(Duration) \_\_\_\_\_ yrs. 6 mos. \_\_\_\_\_ ds.

Contributory Haemorrhage  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 1 ds.

(Signed) B. Kemp Jefferson, M. D.  
May 6, 1914 (Address) Federalburg

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Where was disease contracted, \_\_\_\_\_  
If not at place of death? \_\_\_\_\_  
Former or usual residence. \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Washington Cemetery, Harbeck, Ind. DATE OF BURIAL May 7, 1914

20 UNDERTAKER J. S. Thompson & Son ADDRESS Federalburg, Ind.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

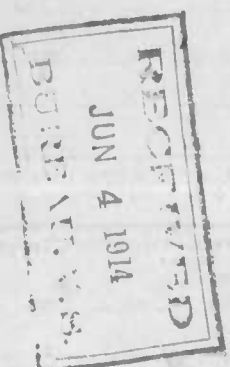
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

|  |   |   |   |   |
|--|---|---|---|---|
| 1 PLACE OF DEATH<br>County <u>Worcester,</u>   |   | 4883  | STATE OF MARYLAND<br>CERTIFICATE OF DEATH |   |
| Village or City <u>near Williamsburg,</u> (No. _____) St.; _____ Ward _____  |   | Registration Dist. No. <u>110</u>   |   | [If death occurred in a hospital or institution, give its NAME instead of street and number.] |
| 2 FULL NAME <u>Still birth (Kennedy)</u>   |   |   |   |   |
| PERSONAL AND STATISTICAL PARTICULARS   |   |   |   |   |
| 3 SEX<br><u>Male.</u>  | 4 COLOR OR RACE<br><u>White.</u>                            | 5 SINGLE, MARRIED, WIDDED, OR DIVORCED<br><u>Single</u><br>(Write the word) |   |   |
| 6 DATE OF BIRTH <u>May, 6<sup>th</sup>, 1914</u><br>(Month) (Day) (Year)   |   |   |   |   |
| 7 AGE<br><u>Still birth</u><br>yrs. ____ mos. ____ ds.   |   | It LESS than 1 day ____ hrs. OR ____ min. ?                                 |   |   |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work. <u>None.</u><br>(b) General nature of industry, business, or establishment in which employed (or employer)  |   |   |   |   |
| 9 BIRTHPLACE (State or country) <u>Maryland.</u>   |   |   |   |   |
| PARENTS  | 10 NAME OF FATHER <u>Daniel J. Kennedy,</u>                 |   |   |   |
|  | 11 BIRTHPLACE OF FATHER (State or country) <u>Maryland.</u> |   |   |   |
|  | 12 MAIDEN NAME OF MOTHER <u>Mary E. Paul,</u>               |   |   |   |
|  | 13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland.</u> |   |   |   |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>Daniel J. Kennedy,</u><br>(Address) <u>Williamsburg, Ind.</u>   |   |   |   |   |
| 15 Filed <u>May 6<sup>th</sup>, 1914</u> <u>Robert L. Hastings</u><br>REGISTRAR  |   |   |   |   |
| MEDICAL CERTIFICATE OF DEATH   |   |   |   |   |
| 16 DATE OF DEATH <u>May 6</u> , 191 <u>4</u><br>(Month) (Day) (Year)   |   |   |   |   |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>Still birth</u> 191 <u>4</u> to <u>1914</u> ,<br>that I last saw him alive on _____, 191 <u>4</u><br>and that death occurred on the date stated above, at <u>2 A</u> m.<br>The CAUSE OF DEATH* was as follows:<br><u>Placenta Praevia</u><br><u>Centralis</u><br>(Duration) ____ yrs. <u>6</u> mos. ____ ds. |   |   |   |   |
| Contributory<br>Secondary<br>(Duration) ____ yrs. ____ mos. ____ ds.   |   |   |   |   |
| (Signed) <u>B. Kemp Jefferson</u> , M. D.<br><u>May 6, 1914</u> (Address) <u>Federalburg, Md.</u>  |   |   |   |   |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.  |   |   |   |   |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.<br>Where was disease contracted, it not at place of death? _____<br>Former or usual residence _____  |   |   |   |   |
| 19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL<br><u>Washington Cemetery, Harlock, Ind.</u> <u>May 7<sup>th</sup>, 1914</u>  |   |   |   |   |
| 20 UNDERTAKER ADDRESS<br><u>J. H. Stratton &amp; Son, Federalburg, Ind.</u>  |   |   |   |   |
| If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.   |   |   |   |   |

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

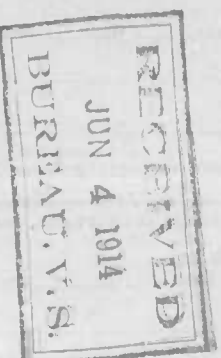
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County DorchesterVillage or City Cambridge (No. 217, High St.; Ward)

## 2 FULL NAME

Margaret A. LewisSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 116

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow  
(Write the word)

6 DATE OF BIRTH Jan. 6<sup>th</sup>, 1885  
(Month) (Day) (Year)

7 AGE 29 yrs. 3 mos. 25 ds. OR 1 day, 1 hrs. 1 min. ?  
If LESS than 1 day, hrs. min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

PARENTS  
10 NAME OF FATHER Bond Marshall  
11 BIRTHPLACE OF FATHER (State or country) Maryland  
12 MAIDEN NAME OF MOTHER Sarah Orem  
13 BIRTHPLACE OF MOTHER (State or country) Maryland

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Mary Lewis(Address) Cambridge Md

15 Filed May 1, 1914 E. E. Wolff

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 1, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from april 25, 1914, to april 25, 1914,  
that I last saw him alive on april 25, 1914.

and that death occurred on the date stated above, at 10:20 m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis(Duration) country yrs. mos. ds.Contributory  
Secondary

(Signed) Wm. H. Miller (Duration) country yrs. mos. ds. M. D.  
5/1, 1914. (Address) Cambridge Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 1 yrs. 3 mos. 25 ds. In the State 1 yrs. 3 mos. 25 ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Antioch Md DATE OF BURIAL May 2nd, 1914

20 UNDERTAKER W. H. Miller DBA ADDRESS Cambridge Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

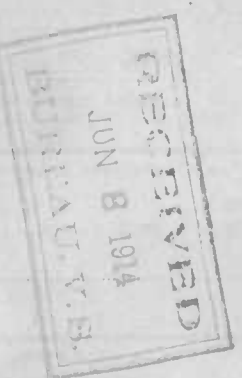
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tubercles of lungs, meningitis, peritonaeum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles, Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 4885

County DorchesterVillage or City Craps (No. 1), \_\_\_\_\_ St.; \_\_\_\_\_ Ward)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 114

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Levin McCreedy

## PERSONAL AND STATISTICAL PARTICULARS

|                      |                                 |   |
|----------------------|---------------------------------|---|
| 3 SEX<br><u>Male</u> | 4 COLOR OR RACE<br><u>Black</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br>(Write the word)<br><u>Married</u> |
|----------------------|---------------------------------|---|

6 DATE OF BIRTH don't know  
(Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) 17 AGE  
about 64 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ min. ?8 OCCUPATION  
(a) Trade, profession, or particular kind of work farmer  
(b) General nature of industry, business, or establishment in which employed (or employer)9 BIRTHPLACE (State or country) Dorchester Co10 NAME OF FATHER don't know11 BIRTHPLACE OF FATHER (State or country) don't know12 MAIDEN NAME OF MOTHER don't know13 BIRTHPLACE OF MOTHER (State or country) don't know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alex McCreedy(Address) Craps15 Filed may 7, 1914 W J Busick  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 5, 1914  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from April 25, 1914, to April 25, 1914.that I last saw him alive on April 25, 1914.and that death occurred on the date stated above, at 5 P. m.

The CAUSE OF DEATH\* was as follows:

Cancer of the eye(Duration) 1 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) R. H. Tawes, M. D.May 6, 1914 (Address) Mingate, Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL McCreedy graveyard DATE OF BURIAL May 7, 191420 UNDERTAKER A J Kirwan ADDRESS Craps

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

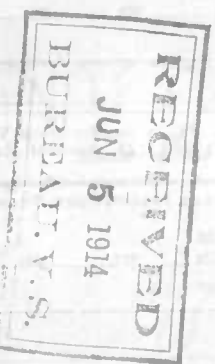
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 4886

County

Dorchester

Village or City

Crapo

(No. \_\_\_\_\_)

St.; \_\_\_\_\_ Ward)

Registration Dist. No.

114

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Infant Mc Cready

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Black

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

April 26, 1914

7 AGE

yrs.

mos.

ds.

1

If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

None

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

David A. Mc Cready

11 BIRTHPLACE OF FATHER (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Dorothy A. Ennalle

13 BIRTHPLACE OF MOTHER (State or country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

David A. Mc Cready

(Address)

Crapo, Md.

15

Filed

May 1, 1914 Wm. J. Curick

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 1

(Month)

(Day)

(Year)

1914

17

I HEREBY CERTIFY, That I attended deceased from

\_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_,

that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_,

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

Convulsions

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

Wm. J. Curick, Jr. Deputy  
Lakesville

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Crapo

May 2, 1914

20 UNDERTAKER

ADDRESS

A. J. Skirvan Crapo

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

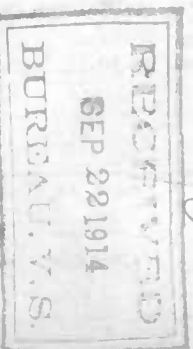
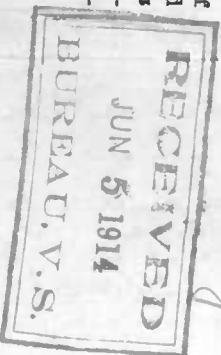
**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) infection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

*Sent out to be signed  
by local registrar*





WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

4887

31

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 116

County DorchesterVillage or City Cambridge (No. \_\_\_\_\_, St.; \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Flora Miller

## PERSONAL AND STATISTICAL PARTICULARS

|  |                                   |   |
|--|-----------------------------------|---|
| 3 SEX<br><u>Female</u>   | 4 COLOR OR RACE<br><u>colored</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br>(Write the word)<br><u>married</u> |
| 6 DATE OF BIRTH<br><u>Unknown</u> , 1 _____<br>(Month) (Day) (Year)  |                                   |   |
| 7 AGE<br><u>25</u> yrs. <u>Unknown</u> mos. _____ ds. _____  |                                   | If LESS than 1 day, _____ hrs. _____ OR _____ min. ?                          |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work<br>(b) General nature of industry, business, or establishment in which employed (or employer)<br><u>Gen. laborer</u> |                                   |   |
| 9 BIRTHPLACE<br>(State or country)<br><u>Ind.</u>  |                                   |   |

## PARENTS

|   |
|---|
| 10 NAME OF FATHER<br><u>Unknown</u>                             |
| 11 BIRTHPLACE OF FATHER<br>(State or country)<br><u>Unknown</u> |
| 12 MAIDEN NAME OF MOTHER<br><u>Unknown</u>                      |
| 13 BIRTHPLACE OF MOTHER<br>(State or country)<br><u>Unknown</u> |

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Reverend J. H. H. H.(Address) Cambridge, Ind.

15

Filed May 25, 1914 E. E. Wolf

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 23, 1914  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to May 22, 1914.that I last saw h. May 22, 1914.and that death occurred on the date stated above, at 2:45 A m.

The CAUSE OF DEATH\* was as follows:

Tuberculosis, intestinalvery moderate (Duration) \_\_\_\_\_ yrs. 2 mos. \_\_\_\_\_ ds.Contributory Acute inflammation  
Secondary Unknown

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Wm. S. S. S., M. D.5/25, 1914 (Address) Cambridge, Ind.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cambridge, Ind.May 25, 1914

20 UNDERTAKER

ADDRESS

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

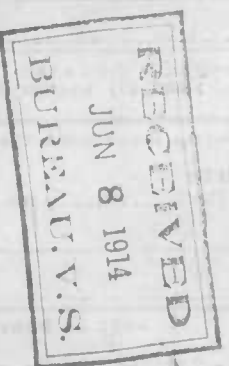
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 4888  
County Dorchester  
Village or City Sturlock (No. 154) St.        Ward         
Registered No. 110

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Joseph M. Murphy

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed  
(Write the word)

6 DATE OF BIRTH Oct. 5, 1829  
(Month) (Day) (Year)

7 AGE 84 yrs. 6 mos. 16 ds. If LESS than 1 day,        hrs. OR        mo. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Blacksmith & Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer) Forming & Genl. Blacksmith

9 BIRTHPLACE (State or country) Penn.

10 NAME OF FATHER James Murphy

11 BIRTHPLACE OF FATHER (State or country) Penn.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) A. M. Shesser  
(Address) Sturlock, Md.

15 Filed May 31<sup>st</sup> 1914 Robert L. Hastings  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 21, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Apr. 11, 1914, to May 20, 1914.

that I last saw him alive on May 20, 1914.

and that death occurred on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH\* was as follows:

Exhaustion from Seizure  
no special disease diagnosed  
(Duration) 1 yrs. 1 mos. 0 ds.

Contributory (Secondary)         
(Duration)        yrs.        mos.        ds.

(Signed) Edward L. Jones, M. D.  
May 21, 1914 (Address) East New Market

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death        yrs.        mos.        ds. In the State        yrs.        mos.        ds.

Where was disease contracted, If not at place of death?

Former or usual residence       

19 PLACE OF BURIAL OR REMOVAL Nutwood, Ohio. DATE OF BURIAL Sept. 1914

20 UNDERTAKER H. H. Mullin ADDRESS Sturlock

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

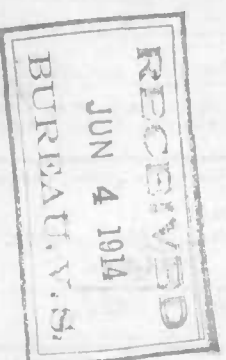
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 4889

County WorcesterVillage or City Vienna

(No. ....)

St.: ..... Ward)

Still-born Pennington.

2 FULL NAME Not namedRegistration Dist. No. 112

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH May 6, 1914  
(Month) (Day) (Year)

7 AGE Three weeks If LESS than 1 day.....hrs.  
.....yrs. ....mos. ....ds. OR ....min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work.....  
(b) General nature of industry, business, or establishment in which employed (or employer).....

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Calvin

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Jackson

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Calvin Pennington

(Address) Vienna, Md.

15 May 6 - 1914 1914 Edward C. Pennington

Local

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 6, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 5th, 1914, to May 6th, 1914, that I last saw him alive on May 6th, 1914.

and that death occurred on the date stated above, at.....m.

The CAUSE OF DEATH\* was as follows:

Chief  
Birth  
(Duration) ..... yrs. .... mos. .... ds.

Contributory  
Secondary

(Signed) E. C. Pennington, M. D.  
May 6 - 1914 (Address) Vienna, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL Vienna, Md DATE OF BURIAL MAY 6 - 1914

20 UNDERTAKER J. B. Pennington (Father) ADDRESS Vienna, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

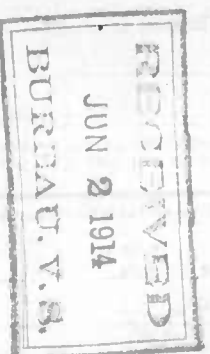
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tracoma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

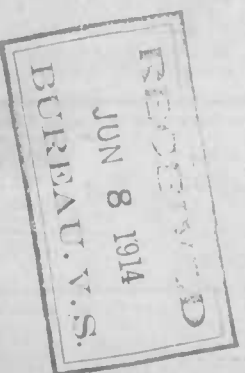
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**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 4891  
County Dorchester

Village or City Cambridge md (No. ...., St.; .... Ward)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 116

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Clarence Plator

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word) infant

6 DATE OF BIRTH May 25, 1914  
(Month) (Day) (Year)

7 AGE Still Born It LESS than 1 day, .... hrs. .... yrs. .... mos. .... ds. OR .... min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work none  
(b) General nature of industry, business, or establishment in which employed (or employer) none

9 BIRTHPLACE (State or country) Cambridge md

10 NAME OF FATHER James L. Plator

11 BIRTHPLACE OF FATHER (State or country) md

12 MAIDEN NAME OF MOTHER Rachel Plator

13 BIRTHPLACE OF MOTHER (State or country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rachel Plator

(Address) Cambridge md

15 Filed May 25, 1914 E. E. Wolff

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 25, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1914 to May 25, 1914  
that I last saw him alive on Still Born, 1914

and that death occurred on the date stated above, at 10 P. m.  
The CAUSE OF DEATH\* was as follows:

Still Born  
baby 7 1/2 to 8 months  
(Duration) .... yrs. .... mos. .... ds.

Contributory  
Secondary

(Signed) Thos. Ignat. Wolf, M. D.  
May 25, 1914 (Address) Cambridge

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cambridge md May 24, 1914

20 UNDERTAKER ADDRESS

Lewis H. Bannerman Cambridge md

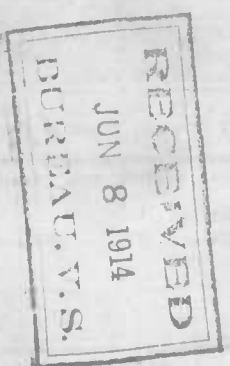
# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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## 1 PLACE OF DEATH

County Dorchester 4892STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 119Village or City Bishop's Head (No. 10)

St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

StillbirthPritchett

## PERSONAL AND STATISTICAL PARTICULARS

|   |                                 |  |
|---|---------------------------------|--|
| 3 SEX<br><u>Male</u>  | 4 COLOR OR RACE<br><u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br><u>Single</u><br>(Write the word) |
| 6 DATE OF BIRTH<br><u>May 8</u> , 1914<br>(Month) (Day) (Year)          |                                 |  |
| 7 AGE<br><u>Stillbirth</u><br>yrs. <u>0</u> mos. <u>0</u> ds. OR min. ? |                                 | If LESS than 1 day, D...hrs.   |

8 OCCUPATION  
(a) Trade, profession, or particular kind of work \_\_\_\_\_  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE  
(State or country) Bishop's Head, Md.

|         |   |
|---------|---|
| PARENTS | 10 NAME OF FATHER<br><u>Franklin A. C. Pritchett</u>                    |
|         | 11 BIRTHPLACE OF FATHER<br>(State or country) <u>Bishop's Head, Md.</u> |
|         | 12 MAIDEN NAME OF MOTHER<br><u>Hattie A. Gleason</u>                    |
|         | 13 BIRTHPLACE OF MOTHER<br>(State or country) <u>Lakesville, Md.</u>    |

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hattie A. Pritchett (Mother)(Address) Bishop's Head Md

15 Filed June 1, 1914 W. H. Pritchett  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 8, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from May 8, 1914, to May 8, 1914, that I last saw him alive on May 8, 1914.

and that death occurred on the date stated above, at 5 A. m.  
The CAUSE OF DEATH\* was as follows:

Premature Birth

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) P. H. Taves, M. D.  
May 8, 1914 (Address) Wingate, Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted,  
If not at place of death?

Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL at Home DATE OF BURIAL May 8, 1914

20 UNDERTAKER Frather ADDRESS Bishop's Head Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

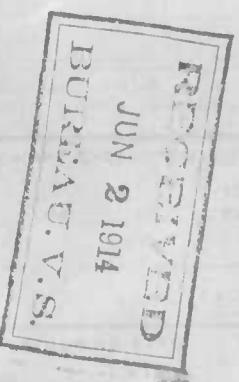
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1 PLACE OF DEATH  
County Dorchester 4893  
Village or City Humboldt (No. : St.; Ward)

2 FULL NAME Infant Sampson

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 110

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single  
6 DATE OF BIRTH May 15<sup>th</sup>, 1914  
(Month) (Day) (Year)  
7 AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 8 ds. If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work \_\_\_\_\_  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Ind

10 NAME OF FATHER Charles N. Sampson  
11 BIRTHPLACE OF FATHER (State or country) Ind  
12 MAIDEN NAME OF MOTHER Rachiel Webb  
13 BIRTHPLACE OF MOTHER (State or country) Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles N. Sampson(Address) Humboldt Ind

15 Filed May 23<sup>rd</sup>, 1914 Robert L. Hastings  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 17, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from Did not attend her  
191\_\_\_\_ to \_\_\_\_\_, 191\_\_\_\_  
Did not see alive  
that I last saw her \_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_

and that death occurred on the date stated above, at 1 P. m.

The CAUSE OF DEATH\* was as follows:

From information gathered  
Chiefly Broncho Pneumonia

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 4 ds.

Contributory (Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) L. G. Teraz, M. D.  
May 23<sup>rd</sup>, 1914 (Address) Humboldt Ind.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Petersburg CemeteryMay 23<sup>rd</sup>, 1914

20 UNDERTAKER

ADDRESS

Charles N. SampsonHumboldt Ind

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

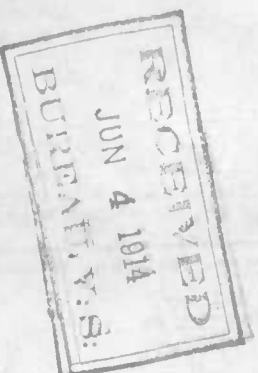
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered, as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

|   |   |  |  |
|---|---|--|--|
| 1 PLACE OF DEATH<br>4894<br>County <u>Dorchester</u>  |   | STATE OF MARYLAND<br>CERTIFICATE OF DEATH<br>Registration Dist. No. <u>112</u> |  |
| Village or City <u>Vienna R.D.#2</u><br>(No. <u>40</u> )  |   | St.: _____ Ward) _____   |  |
| 2 FULL NAME <u>Lizzie J. Sellers</u>  |   |  |  |
| PERSONAL AND STATISTICAL PARTICULARS  |   |  |  |
| 3 SEX<br><u>Female</u>  | 4 COLOR OR RACE<br><u>White</u>                               | 5 SINGLE, MARRIED, WIDDED, OR DIVORCED<br>(Write the word) <u>Married</u>      |  |
| 6 DATE OF BIRTH<br><u>Sept 22</u> , 18 <u>81</u><br>(Month) (Day) (Year)  |   |  |  |
| 7 AGE<br><u>62</u> yrs. <u>8</u> mos. <u>7</u> ds. If LESS than 1 day, _____ hrs. OR _____ min. ?   |   |  |  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work <u>Housewife</u><br>(b) General nature of industry, business, or establishment in which employed (or employer) _____  |   |  |  |
| 9 BIRTHPLACE<br>(State or country) <u>Maryland</u>  |   |  |  |
| PARENTS   | 10 NAME OF FATHER <u>Washington Rumble</u>                    |  |  |
|   | 11 BIRTHPLACE OF FATHER<br>(State or country) <u>Maryland</u> |  |  |
|   | 12 MAIDEN NAME OF MOTHER <u>LeCompte</u>                      |  |  |
| 13 BIRTHPLACE OF MOTHER<br>(State or country) <u>Maryland</u>   |   |  |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>Fred Sellers</u><br>(Address) <u>Vienna R.D.#2</u>   |   |  |  |
| 15<br>JUN 1 - 1914<br>Filed _____, 191 <u>4</u><br><u>Edward F. Lankin</u><br><u>Local</u> REGISTRAR  |   | 16 DATE OF DEATH<br><u>May 29</u> , 191 <u>4</u><br>(Month) (Day) (Year)       |  |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>May 14</u> , 191 <u>4</u> , to <u>May 28</u> , 191 <u>4</u> , that I last saw him alive on <u>May 28</u> , 191 <u>4</u> , and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:<br><u>Baron's of Stomach</u><br><u>&amp; Intestinal rupture</u><br>(Duration) _____ yrs. _____ mos. _____ ds. |   |  |  |
| Contributory<br>Secondary _____<br>(Duration) _____ yrs. _____ mos. _____ ds.   |   |  |  |
| (Signed) <u>H. F. Neels</u> , M. D.<br><u>May 29</u> , 191 <u>4</u> (Address) <u>2 n. market st</u>   |   |  |  |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.   |   |  |  |
| 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)<br>At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.<br>Where was disease contracted, If not at place of death? _____<br>Former or usual residence _____   |   |  |  |
| 19 PLACE OF BURIAL OR REMOVAL<br><u>Vienna R.D.#2</u>   |   | DATE OF BURIAL<br><u>May 30</u> , 191 <u>4</u>                                 |  |
| 20 UNDERTAKER<br><u>LeCompte Harper</u>   |   | ADDRESS<br><u>Cambridge</u>  |  |



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

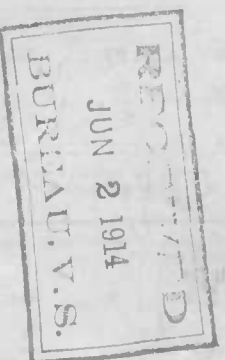
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inauition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on Statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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4895

## 1 PLACE OF DEATH

County

*Douhetin*

Village or City

*Golden Hill*

(No.)

Registration Dist. No.

*118*

St.; Ward)

[It death occurred to a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

*Arthur Preston Stanley*

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male*

## 4 COLOR OR RACE

*Col*

## 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

*Married*

## 6 DATE OF BIRTH

*Oct 4, 1889*  
(Month) (Day) (Year)

## 7 AGE

*24 yrs. 7 mos. 26 ds.* It LESS than 1 day,.....hrs. OR.....mo.?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work

*Farmer*

(b) General nature of industry, business, or establishment in which employed (or employer)

## 9 BIRTHPLACE (State or country)

*Maryland*

## PARENTS

## 10 NAME OF FATHER

*William Stanley*

## 11 BIRTHPLACE OF FATHER (State or country)

*Maryland*

## 12 MAIDEN NAME OF MOTHER

*Mary P. Garrison*

## 13 BIRTHPLACE OF MOTHER (State or country)

*Maryland*

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*William Stanley*

(Address)

*Church Creek*

## 15

Filed

*June 2, 1914*

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

*May 30, 1914*  
(Month) (Day) (Year)

## 17

I HEREBY CERTIFY, That I attended deceased from

....., 191....., to....., 191.....  
that I last saw h..... alive on....., 191.....

and that death occurred on the date stated above, at *5.30 P.m.*

The CAUSE OF DEATH\* was as follows:

*Accidental Drowning*

(Duration).....yrs.....mos.....ds.

Contributory (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed)

*R. L. Linthicum*, M. D.*June 1st, 1914* (Address) *Church Creek, Md.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

*Golden Hill**June 1, 1914*

## 20 UNDERTAKER

## ADDRESS

*Donnell Richardson Church Creek*

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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*oma*, *Sarcoma*, etc., of ----- (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JUN 5 1914

BUREAU, U. S.

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1 PLACE OF DEATH 4896  
County Dorchester

Village or City Galestown (No. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registered No. 100

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

FULL NAME Mary A Stanton

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH June 10<sup>th</sup>, 1839  
(Month) (Day) (Year)

7 AGE 74 yrs. 10 mos. 24 ds. OR LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Dorchester County Md

10 NAME OF FATHER Chas Vickers

11 BIRTHPLACE OF FATHER (State or country) Dorchester Co Md

12 MAIDEN NAME OF MOTHER Sallie Griffith

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C W Stanton

(Address) Galestown Md

15 Filed May 10<sup>th</sup>, 1914 J. H. Hastings  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 9, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 1912, to May 9, 1914.

that I last saw him alive on May 9, 1914.

and that death occurred on the date stated above, at 8:00 m.

This CAUSE OF DEATH\* was as follows:

Cancer  
of face  
(Duration) 7 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (Secondary)

(Signed) C. H. Oster, M. D.  
(Address) Seaford Del, 191 \_\_\_\_\_

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 14 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Galestown DATE OF BURIAL May 11<sup>th</sup>, 1914

20 UNDERTAKER J. H. Thompson & Son ADDRESS Federalburg Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

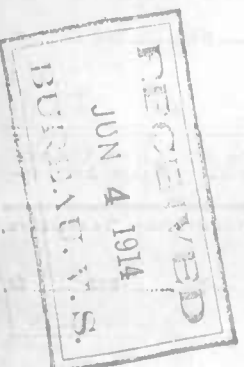
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1 PLACE OF DEATH

4897

County

Dorchester

 STATE OF MARYLAND  
 CERTIFICATE OF DEATH

Registration Dist. No.

116

Village or City

Cambridge

(No. \_\_\_\_\_)

St.;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Infant St Clair

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

 5 SINGLE,  
 MARRIED,  
 WIDDED,  
 OR DIVORCED  
 (Write the word)

Single

6 DATE OF BIRTH

 May 22, 1914  
 (Month) (Day) (Year)

7 AGE

Still-born

 If LESS than  
 1 day, \_\_\_\_ hrs.  
 \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. OR \_\_\_\_ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Ind.

PARENTS

10 NAME OF FATHER

Cyrus St Clair Jr.

11 BIRTHPLACE OF FATHER (State or country)

Ind.

12 MAIDEN NAME OF MOTHER

Bertha Nixon

13 BIRTHPLACE OF MOTHER (State or country)

Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Cyrus St Clair Jr.

(Address)

Cambridge, Md.

15

Filed

June 5, 1914

E. E. Wolff

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

 May 22, 1914  
 (Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

 May 22, 1914  
 (Month) (Day) (Year)

that I last saw him on

May 22, 1914

and that death occurred on the date stated above, at

The CAUSE OF DEATH\* was as follows:

 Child under 1 year. Apparently  
 died as a result of pneumonia

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory

Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed)

G. E. Smith

M. D.

 (Address) Cambridge, Md.  
 1914

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Cambridge, Md.

DATE OF BURIAL

May 22, 1914

20 UNDERTAKER

Buried in yard.

ADDRESS

Cambridge, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

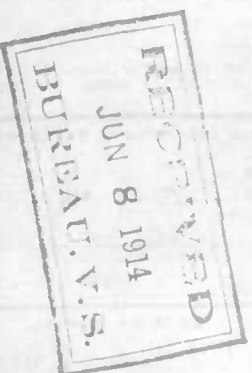
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Scutle," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1898

## 1 PLACE OF DEATH

County

*Dorchester*STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *113*

Village or City

*Taylor's Island*

(No. \_\_\_\_\_)

St.; \_\_\_\_\_ Ward)

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

2 FULL NAME

*Genevieve W. Thompson**(Illegitimate)*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*Blk*5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)*Single*

6 DATE OF BIRTH

*Feb.**7**1914*

(Month)

(Day)

(Year)

7 AGE

*#*

yrs.

*3*

mos.

*12*

ds.

It LESS than

1 day.....hrs.

OR.....min. ?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work*none*(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE

(State or country)

*md*

## PARENTS

10 NAME OF  
FATHER*Steven Jennifer*11 BIRTHPLACE  
OF FATHER  
(State or country)*md*12 MAIDEN NAME  
OF MOTHER*Leana Thompson*13 BIRTHPLACE  
OF MOTHER  
(State or country)*md*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Sam J. Thompson*

(Address)

*Taylor's Island, md*

15

Filed

*May 20**1914**Jo K. Shivers*  
*Local REGISTRAR*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*May**19**1914*

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

191....., to

191.....,

that I last saw h..... alive on....., 191.....

and that death occurred on the date stated above, at *5 A.* m.

The CAUSE OF DEATH\* was as follows:

*Inanition - due to improper  
food*(Duration) — yrs. *3* mos. *7* ds.

Contributory

Secondary

(Duration) — yrs. .... mos. .... ds.

(Signed)

*Thos. W. Riepert, M.D.*  
*acting coroner*  
*May 20, 1914* (Address) *Taylor's Island, md*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
SUICIDAL, or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place

of death

yrs. .... mos. .... ds.

In the

State

yrs. .... mos. .... ds.

Where was disease contracted,  
If not at place of death?Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Taylor's Island md**May 21, 1914*

20 UNDERTAKER

ADDRESS

*Henry W. Lambdin**Taylor's Island md*

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MARGIN RESERVED FOR BINDING

V. S. No. 1.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH 4899

County

Dorchester

Village or City

Cambridge

(No.

St.;

Ward)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 116

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Hazel B. Popper

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Single

6 DATE OF BIRTH

Aug

(Day)

1, 1896

(Year)

7 AGE

17 yrs.

8 mos.

22 ds.

If LESS than  
1 day, hrs.  
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

John Popper

11 BIRTHPLACE OF FATHER  
(State or country)

Kansas

12 MAIDEN NAME OF MOTHER

Annie R. Parsons

13 BIRTHPLACE OF MOTHER  
(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Annie R. Popper

(Address)

Salisbury Md

15

Filed

May 23, 1914

E. E. Dole

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 20

(Month)

(Day)

1914 (Year)

17

I HEREBY CERTIFY, That I attended deceased from

May 18

1914

May 20

1914

that I last saw him alive on May 22, 1914

and that death occurred on the date stated above, at 8 a. m.

The CAUSE OF DEATH\* was as follows:

mercuric chloride poisoning  
suicide

(Duration)

— yrs.

— mos. 19 ds.

Contributory

Mercuric Chloride +

Secondary

(Duration)

— yrs.

— mos. 1 ds.

(Signed)

Guy Steile

M. D.

5/23

1914

(Address)

Cambridge Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs. mos. ds.

In the

State

yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Salisbury Md

5/24, 1914

20 UNDERTAKER

ADDRESS

W. H. H. H. H. H.

Cambridge Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

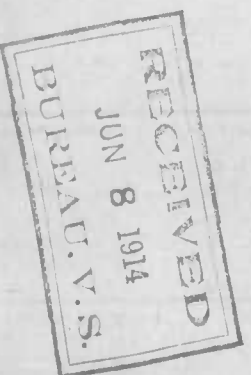
[Approved by U. S. Census and American Public Health Association.]

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Dorchester

4900

(120)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 116

Village or City Mary Hughes Mission (No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary E. Ward

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE colored 5 SINGLE, MARRIED, WIDOWED, married OR DIVORCED (Write the word)

6 DATE OF BIRTH Unknown, 1857  
(Month) (Day) (Year)

7 AGE 57 yrs. 0 mos. 0 ds. If LESS than 1 day, 0 hrs. OR 0 min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work house wife  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Ind.

PARENTS  
10 NAME OF FATHER Charles Bryant  
11 BIRTHPLACE OF FATHER (State or country) Ind.  
12 MAIDEN NAME OF MOTHER Unknown  
13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert Ward

(Address) Black water near Hughes Mission

15 Filed July 22, 1914 EE Wolfe  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 21, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from about Nov., 1913, to \_\_\_\_\_, 191\_\_\_\_,

that I last saw him alive on about Nov., 1913.

and that death occurred on the date stated above, at 6 A. m.

The CAUSE OF DEATH\* was as follows:

Chronic nephritis & Valvular Heart Disease  
(Duration) Unknown yrs. 0 mos. 0 ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) EE Wolfe, M. D.  
July 22, 1914 (Address) Cambridge Ind.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Cambridge, Ind. DATE OF BURIAL May 21, 1914

20 UNDERTAKER James B. Blair ADDRESS City

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

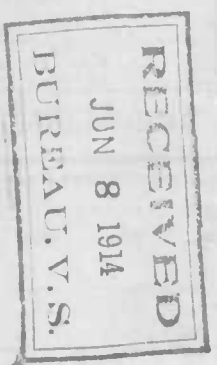
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1 PLACE OF DEATH 4901  
County Dorchester  
Village or City Church Creek (No. \_\_\_\_\_) St.; \_\_\_\_\_ Ward)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 118

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John Wesley Warters

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Col 5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word)

6 DATE OF BIRTH July 30, 1912  
(Month) (Day) (Year)

7 AGE 1 yrs. 9 mos. 20 ds. If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work \_\_\_\_\_  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER John Warters

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Melvin Barclay

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Warters

(Address) Woolford

15 Filed June 2, 1914 John P. Justice

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 20, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 18, 1914 to May 20, 1914.

that I last saw him alive on May 18, 1914.

and that death occurred on the date stated above, at 6:00 m.

The CAUSE OF DEATH\* was as follows:

Spinal meningitis

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 7 ds.

Contributory (Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) V. H. Carroll, M. D.

May 21, 1914 (Address) Lanham, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Madison

DATE OF BURIAL May 21, 1914

20 UNDERTAKER Donald Richardson

ADDRESS Church Creek

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

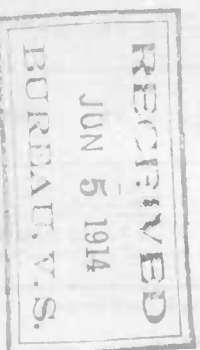
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative wealthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plaster, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc.. *Carcin-*

*oma, Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *10 ds.* Never report *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

|  |  |   |   |   |  |  |  |
|--|--|---|---|---|--|--|--|
| 1 PLACE OF DEATH<br>County <u>Dorchester</u>   |  | 4902  |   | (66)  |  | STATE OF MARYLAND<br>CERTIFICATE OF DEATH      |  |
| Village or City <u>Secretary</u>   |  | (No. _____)   |   | St.; _____  |  | Ward) _____                                    |  |
| 2 FULL NAME <u>Deborah Wheatley</u>  |  | Registered No. <u>111</u>   |   |   |  |  |  |
| PERSONAL AND STATISTICAL PARTICULARS   |  |   |   | MEDICAL CERTIFICATE OF DEATH  |  |  |  |
| 3 SEX<br><u>Female</u>   | 4 COLOR OR RACE<br><u>White</u>  | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br><u>widowed</u><br>(Write the word)                       |   | 16 DATE OF DEATH <u>May 23</u> , 191 <u>4</u><br>(Month) (Day) (Year)   |  |  |  |
| 6 DATE OF BIRTH<br><u>July 25</u> , 18 <u>44</u><br>(Month) (Day) (Year)   |  | 7 AGE<br><u>69</u> yrs. <u>9</u> mos. <u>28</u> ds.<br>IF LESS than 1 day, ____ hrs. OR ____ min. ? |   | 17 I HEREBY CERTIFY, That I attended deceased from <u>May 23</u> , 191 <u>4</u> , to <u>May 23</u> , 191 <u>4</u> .<br>that I last saw her alive on <u>May 23</u> , 191 <u>4</u> .<br>and that death occurred on the date stated above, at <u>11:20</u> a.m.<br>The CAUSE OF DEATH* was as follows:<br><u>Paralysis</u> |  |  |  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work. <u>none</u><br>(b) General nature of industry, business, or establishment in which employed (or employer) <u>none</u> |  | 9 BIRTHPLACE<br>(State or country) <u>Maryland</u>  |   | Contributory (Secondary) _____<br>(Duration) _____ yrs. _____ mos. <u>3 hrs</u>   |  |  |  |
| PARENTS  | 10 NAME OF FATHER <u>Martin Corkran</u>  | 11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u>   |   | (Signed) <u>Edward L. Jones</u> , M. D.<br><u>May 24</u> , 191 <u>4</u> (Address) <u>E. N. Market Md</u>  |  |  |  |
|  | 12 MAIDEN NAME OF MOTHER <u>Marguerite Corkran</u>   | 13 BIRTHPLACE OF MOTHER (State or country) <u>Md.</u>   |   | *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.   |  |  |  |
|  | 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>George Murphy</u><br>(Address) <u>East New Market, Md</u> |   | 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.<br>Where was disease contracted, if not at place of death? _____<br>Former or usual residence _____ |   |  |  |  |
| 15 Filled _____, 191____   |  | REGISTRAR   |   | 19 PLACE OF BURIAL OR REMOVAL<br><u>E. N. Market Md</u>   |  | DATE OF BURIAL<br><u>May 25</u> , 191 <u>4</u> |  |
|  |  |   |   | 20 UNDERTAKER<br><u>W. H. Mellow</u>  |  | ADDRESS<br><u>E. N. Market Md.</u>             |  |

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

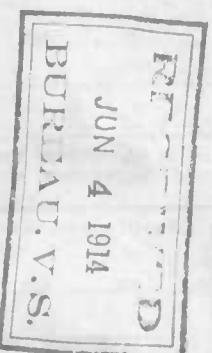
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

*oma. Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 4903  
County Dorchester

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 116

Village or City Cambridge (No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Helena Whealley

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH Unknown, 1891  
(Month) (Day) (Year)

7 AGE 23 yrs. Unknown If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work. Gen. Laborer  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Ind.

PARENTS  
10 NAME OF FATHER Jas. Stewart  
11 BIRTHPLACE OF FATHER (State or country) Ind.  
12 MAIDEN NAME OF MOTHER Catherine Elliott  
13 BIRTHPLACE OF MOTHER (State or country) Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ernest Whealley

(Address) Cordtown, Ind.

15 Filed May 14, 1914 ER Wolff

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 13, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1914, to May 13, 1914, that I last saw him alive on May 13, 1914

and that death occurred on the date stated above, at 11.40 A.M.

The CAUSE OF DEATH\* was as follows:

Periparturient Eclampsia -  
(about 4 1/2 hrs. pregnant)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) ER Wolff, M. D.  
May 14, 1914 (Address) Cambridge, Ind.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cordtown, Ind. May 14, 1914

20 UNDERTAKER ADDRESS

Turner & Schlar city

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

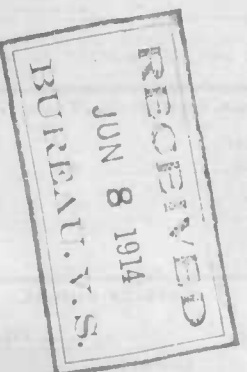
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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc.—State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

4904

County

Dorchester

Village or City

Cambridge

(No.)

Cambridge - Ind. Hspt.

Registration Dist. No.

116

St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Infant Wheatley

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male (?)

4 COLOR OR RACE

Colored

5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

May 13, 1914

(Month)

(Day)

(Year)

7 AGE

— yrs. — mos. — ds.

If LESS than 1 day, hrs. OR 30 min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Ind.

10 NAME OF FATHER

Earnest Wheatley

11 BIRTHPLACE OF FATHER (State or country)

Ind.

12 MAIDEN NAME OF MOTHER

Helen Wheatley

13 BIRTHPLACE OF MOTHER (State or country)

Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Earnest Wheatley

(Address)

Dorchester, Ind.

15

Filed

May 13, 1914

E. E. Wolff

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 13, 1914

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

on May 13, 1914, to

that I last saw him alive on May 13, 1914

and that death occurred on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH\* was as follows:

Premature Birth (4 1/2 months about)

(Duration) yrs. mos. ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed)

E. E. Wolff

M. D.

May 13, 1914. (Address) Cambridge Ind.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Cambridge Ind. Hspt.

DATE OF BURIAL

May 13, 1914

20 UNDERTAKER

Ordery

ADDRESS

Cambridge Ind.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *20 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Strike by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 4905  
 County Dorchester  
 Village or City Cambridge (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_  
 2 FULL NAME Ida M. Miller  
 [It death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
 (Write the word)  
 6 DATE OF BIRTH Unknown, 1887  
 (Month) (Day) (Year)  
 7 AGE 27 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?  
 8 OCCUPATION  
 (a) Trade, profession, or particular kind of work House work  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 9 BIRTHPLACE (State or country) Maryland

## PARENTS

10 NAME OF FATHER Don't know  
 11 BIRTHPLACE OF FATHER (State or country) Don't know  
 12 MAIDEN NAME OF MOTHER Don't know  
 13 BIRTHPLACE OF MOTHER (State or country) Don't know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. F. Nicols  
 (Address) E. N. Market, Md

15 Filed July 24, 1914 E. E. Walcott  
 REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 116

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 24, 1914  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_,

that I last saw him alive on May 22, 1914

and that death occurred on the date stated above, at 6.45 a.m.

The CAUSE OF DEATH\* was as follows:

Pelvic abscess Peritonitis  
T.B.

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 14 ds.

Contributory  
 Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) H. F. Nicols, M. D.  
July 24, 1914. (Address) E. N. Market, Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Storwade, Md. DATE OF BURIAL May 25, 1914

20 UNDERTAKER W. H. Miller & Bro ADDRESS Cambridge, Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

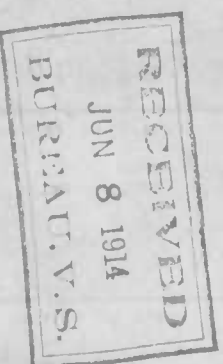
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremnia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

4906

County Sorchester

(28)

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 116Village or City Cambridge (No. Parklane St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Emily Winge

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE colored 5 SINGLE, MARRIED, WIDOWED, DIVORCED widow  
(Write the word)

6 DATE OF BIRTH Unknown <sup>about</sup> 1847  
(Month) (Day) (Year)

7 AGE about 66 yrs. 26 mos. 4 ds. OR 1 day, 1 hrs. 1 min. ?  
If LESS than 1 day, hrs. min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Dom. Laborer  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Ind.

PARENTS  
10 NAME OF FATHER Unknown  
11 BIRTHPLACE OF FATHER (State or country) Unknown  
12 MAIDEN NAME OF MOTHER Unknown  
13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Annie Turner(Address) Bridge St. city

15 Filed May 9, 1914 EEWapp  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 9, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from about April 10, 1914, to about Apr. 10, 1914.

that I last saw him alive on about Apr. 10, 1914.

and that death occurred on the date stated above, at about 4 A. m.

The CAUSE OF DEATH\* was as follows:

Probably Tuberculosis (Pulm.)

(Duration)        yrs.        mos.        ds.Contributory  
Secondary(Duration)        yrs.        mos.        ds.

(Signed) EEWapp, M. D.  
May 9, 1914 (Address) Cambridge, Ind.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR REGENT RESIDENTS)

At place of death        yrs.        mos.        ds. In the State        yrs.        mos.        ds.

Where was disease contracted, If not at place of death?

Former or usual residence       

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cambridge, Ind. May 11, 1914

20 UNDERTAKER ADDRESS

Turner & Co. Clair city

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

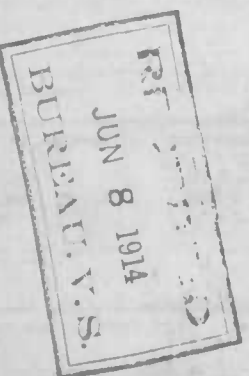
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Cool mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 4907  
County Dorchester

Village or City Hicksbury (No. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

(15) STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 116

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Infant Young

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH May 13, 1914  
(Month) (Day) (Year)

7 AGE Still-born If LESS than 1 day, \_\_\_\_ hrs. \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. OR \_\_\_\_ min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Infant  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Ind.

PARENTS  
10 NAME OF FATHER Howard Young  
11 BIRTHPLACE OF FATHER (State or country) Ind.  
12 MAIDEN NAME OF MOTHER Rhynia Wilson  
13 BIRTHPLACE OF MOTHER (State or country) Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Howard Young  
(Address) Cambridge, Md. R. F. D. #2

15 Filed May 13, 1914 E. E. Wolff  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 13, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from not at all, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_,

that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

Still-born  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Signed) E. E. Wolff L. R., M. D.  
May 13, 1914 (Address) Cambridge, Ind.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL The Bride Farm, Dr. Co. Ind. DATE OF BURIAL May 14, 1914

20 UNDERTAKER Howard Willoughby ADDRESS East New Market, Ind.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by barbitic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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